AFTER THE STORM

PROMOTING SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS IN THE AFTERMATH OF DISASTER IN THE PHILIPPINES

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ABOUT THE RESEARCH

• Supported through a grant from the International Association for the Study of Sexuality Culture and Society
• Explores the intersection of sexual and reproductive health, development, and human rights in the context of managing post-disaster relief and rehabilitation operations
• As a case study, it investigates the disaster response and rehabilitation efforts carried out in southern Philippines after the devastation wrought by Tropical Storm Washi (a.k.a. Sendong)
METHODS

• Key informant interviews with service providers
• Group discussions and body mapping exercises for disaster survivors living in evacuation centers
• Socio-demographic and reproductive health survey of 494 IDPs (101 men and 393 women) in four evacuation camps in the Iligan City
Sexual and Reproductive Health in post-disaster settings within a human rights framework

Illustrate “everyday life” in the IDP camps

Reflect on how disaster response machineries draw upon biomedical management frameworks in addressing SRH needs and conditions of disaster survivors
With the ICPD held in Cairo in 1994, a significant shift from the narrow focus on fertility and population management to a broader agenda that addresses issues of sexual and reproductive health using the language of human rights.
With the issues of climate change and disaster risk reduction gaining momentum in the global development arena, one can also ask: in what ways are the interventions that have been developed to manage climate and disaster risks (em)bodyed?
AFTER THE STORM
SENDONG IN RETROSPECT

- Second deadliest disaster in 2011 internationally
- resulted in more than 1,500 fatalities
- displaced an estimated 430,900 people (IDMC-NRC, 2013)
Seven months after...
SEX AND THE (TENT) CITY

By February 2012, a total of 47 evacuation camps had been set up in and around Cagayan de Oro and Iligan cities catering to 21,448 people out of the hundreds of thousands more who had been displaced by the floods.
Some facilities found in IDP camps
It was reported that in the early months after the disaster, pregnant and lactating mothers comprised over 5% of the affected populations or roughly around 29,970 women, 40 percent of whom were between the ages of 15-19 years.
ISSUES INSIDE THE CAMP

- Resettlement and relocation
- Privacy in the camps (sometimes leading to sexual abuse)
- Possibilities of human trafficking
- “Baby boom”
- “Where to have sex?”
GENDER-BASED VIOLENCE

• Gender-based violence (GBV) is also serious but inadequately documented problem in the evacuation sites
• “GBV is no longer our concern because our focus now is livelihood.”
• Lack of sensitivity of service providers
Cases of gender-based violence that occurred in the 4 evacuation sites since TS Sendong documented through the SDRHS July 2012

<table>
<thead>
<tr>
<th>Gender</th>
<th>Physical violence</th>
<th>Threats and intimidation, verbal abuse</th>
<th>Forced detention</th>
<th>Acts of lasciviousness</th>
<th>Sexual violence</th>
<th>Total</th>
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</thead>
<tbody>
<tr>
<td>Male</td>
<td>5</td>
<td>7</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>21</td>
</tr>
<tr>
<td>Female</td>
<td>19</td>
<td>26</td>
<td>8</td>
<td>11</td>
<td>12</td>
<td>76</td>
</tr>
<tr>
<td>Total</td>
<td>24</td>
<td>33</td>
<td>10</td>
<td>14</td>
<td>16</td>
<td>97</td>
</tr>
</tbody>
</table>
WHO ARE THE ‘VULNERABLE’?

In disaster risk management-speak, vulnerability refers to “the diminished capacity of an individual or group to anticipate, cope with, resist and recover from the impact of a natural or [human-made] hazard” (IFRC, n.d.).
CONSTRUCTING VULNERABILITIES

Intersections of gender, sexuality, age, ethnicity and so forth within the socio-spatial context of post-disaster displacement can offer a broader understanding of vulnerability, as well as the conditions that would allow people to overcome such.
ACCESSING SRH SERVICES, INFORMATION AND RIGHTS

- Normative frames about the gendered/sexual body of the refugees have tended to discriminate against the unmarried, the young, or the old.
- “I am not their main concern since I am already old and can no longer bear children”
- Beliefs that SRH was mainly for married women was a widely held assumption
- Marginalization of non-normative sexualities
NORMATIVE FRAMES

In other words, underpinning these assumptions about who should be prioritized (and targeted) in the delivery of SRH services are powerful heteronormative and marriage-normative frames informed by the reproductive essentialization of women’s bodies as vulnerable bodies. These framings of vulnerability also feed into the ways the camps are administered, and how sexuality and reproduction are spoken about, attended to, and eventually managed.
MANAGING REPRODUCTIVE BODIES

- Systems of management included: surveillance of whereabouts of IDPs, health conditions, concerns, and activities; identification cards as evidence of being a “legitimate IDP”
- “Look at them, they are too lazy to find work. All they do is depend on aid.”
- Distribution of condoms → mixed reactions
- Other SRH services provided: “parenting” seminars, providing vitamins to pregnant and lactating women, ante-natal check-ups, and promoting proper hygiene.
SRH came to be understood mainly in terms of planning pregnancies, curbing maternal deaths, preventing sexually transmitted infections, caring for newborns and infants, maintaining sanitation, and providing healthcare facilities.
BIOPOLITICAL RESPONSE TO SRH

• It is women’s bodies that take on the burden of curbing the “population problems” perceived to be propagating in the camps by becoming objects for the management of reproductive risks.
• Implicit resistance to objectify men’s bodies in the same way.
• Women survivors employed the same language through which they have been made to understand what sexual and reproductive health was.
CONCLUSION

• Humanitarian and government agencies do address to a certain extent issues relevant to SRH.
• Challenges in achieving SRHR run deeper than the mere lack of access to, or absence of, SRH services, as the delivery of such remain imbricated in gender/sexual power relations which are heavily marked by various divisions such as class, age, ethnicity, and even civil status.
• There has been a tendency to privilege the discourse of “health”, “aid”, and “hygiene” when speaking of the sexual and reproductive health of disaster survivors. Such discourse elides the gendered and sexual dimensions of disasters, and this elision in effect depoliticizes gender/sexual relations and the body by reducing such into technical problems with technical solutions.
RIGHTS-BASED APPROACH

• a necessary entry point towards calling attention to the ability of disaster survivors to negotiate their specific political positions with regard to the decisions that have often been made for them and rarely with them.

• is a need to review and to change current humanitarian relief models that tend to be “disempowering and paternalistic” by casting disaster survivors as merely passive, dependent, and vulnerable victims rather than as political agents.

• a rights-based framework would also serve to repoliticize sexuality, sexual and reproductive health, and the body in order to enable survivors to make “social and gender justice claims and to provide [as well as develop] mechanisms for holding governments, private corporations, and international agencies accountable” (Petchesky, 2005, p. 303).
Thank you!